Welcome & Introductions

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Clinical Project Consultant
The Nation’s Opioid Epidemic

• The Opioid Crisis
• Colorado ALTO Project
• IHA Opioid Alternative Project
THE OPIOID EPIDEMIC BY THE NUMBERS

IN 2016...

116
People died every day from opioid-related drug overdoses

11.5 m
People misused prescription opioids

42,249
People died from overdosing on opioids

2.1 million
People had an opioid use disorder

948,000
People used heroin

170,000
People used heroin for the first time

2.1 million
People misused prescription opioids for the first time

17,087
Deaths attributed to overdosing on commonly prescribed opioids

19,413
Deaths attributed to overdosing on synthetic opioids other than methadone

15,469
Deaths attributed to overdosing on heroin

504 billion
In economic costs

Sources: ¹ 2016 National Survey on Drug Use and Health, ² Mortality in the United States, 2016 NCHS Data Brief No. 293, December 2017, ³ CEA Report: The underestimated cost of the opioid crisis, 2017
Dramatic Increases in Overdose Deaths in Every State

Estimated Age-Adjusted Death Rates for Drug Poisoning by County, United States in Every State
Opioid overdoses went up 30% from July 2016 through September 2017 in 52 areas in 45 states.

The Midwestern region saw opioid overdoses increase 70% from July 2016 through September 2017.

Opioid overdoses in large cities increased by 54% in 16 states.

Opioid overdose ED visits continued to rise from 2016 to 2017.

Detecting recent trends in opioid overdose ED visits provides opportunities for action in this fast-moving epidemic.

PERCENT CHANGE
- Decrease
- Increase 1 to 24%
- Increase 25 to 49%
- Increase 50% or more
- Data unavailable

SOURCE: CDC’s Enhanced State Opioid Overdose Surveillance (ESOOS) Program, 16 states reporting percent changes from July 2016 through September 2017.
US Life Expectancy Decreased in 2017 - Largely due to Drug Overdose Deaths
2018: How Did We Get Here?

1. Pain Being Designated The Fifth Vital Sign
2. Under Appreciation of Addictive Potential of Prescription Opioids
3. Aggressive Marketing of Prescription Opioids to Clinicians
4. Clinicians Who Ran Pill Mills that Profited from Over Prescribing
5. Sophisticated Actions of Drug Traffickers to Open New Heroin Markets
6. Potency and Ease of Making, Trafficking, and Profiting from Illicit Fentanyl and Fentanyl Analogs

UNITED STATES OPIOID EPIDEMIC
ED’s, ED Providers and Others have Stepped Up in Many Ways:

- I-Stop Program
- Limiting Prescription Duration
- Initiating Suboxone Treatment
- Widespread Narcan Availability
- Bridge Clinics
- Community Treatment Links to ED
- ALTO Use in ED
10 participating EDs
  • voluntary
  • region
  • urban/rural status
Based on Colorado ACEP guidelines
Launched and administered by the Colorado Hospital Association (CHA)
Aim: Reduce administration of opioids by 15% measured in morphine equivalent units (MEUs) over the 2017 6-month pilot period, as compared with the same 6-month baseline period in 2016
Figure 6: Analgesic Treatment (ALTO vs. Opioid Percent of Total Unique Visits) by Medical Condition

- **Kidney Stones**
  - 2016: 69% (ALTO) 31% (Opioid)
  - 2017: 47% (ALTO) 53% (Opioid)

- **Back Pain/Lumbago**
  - 2016: 65% (ALTO) 35% (Opioid)
  - 2017: 39% (ALTO) 61% (Opioid)

- **Headaches/Migraine**
  - 2016: 42% (ALTO) 58% (Opioid)
  - 2017: 20% (ALTO) 80% (Opioid)

- **Arm/Leg Fractures & Dislocations**
  - 2016: 83% (ALTO) 17% (Opioid)
  - 2017: 77% (ALTO) 23% (Opioid)

- **Unspecified Abdominal Pain**
  - 2016: 77% (ALTO) 23% (Opioid)
  - 2017: 50% (ALTO) 50% (Opioid)

- **Malignant Neoplasms**
  - 2016: 93% (ALTO) 7% (Opioid)
  - 2017: 84% (ALTO) 16% (Opioid)
OVERVIEW: IHA Opioid Alternative Project

**WHAT**
Pilot program with the primary goal of reducing opioid usage in Upstate NY EDs through physician and hospital collaboration to administer alternative opioid pain treatments

**WHO**
15-20 Acute Care EDs
Mix of designated Urban and Rural hospitals

**WHERE**
Upstate New York – IHA Region
In 1 or more geographic sub-regions

**WHEN**
April 1, 2018 – March 31, 2019 (NYS fiscal year)
Includes data collection
<table>
<thead>
<tr>
<th>CORE HOSPITALS CAPITAL REGION</th>
<th>CORE HOSPITALS CENTRAL NY</th>
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<tbody>
<tr>
<td>Albany Medical Center</td>
<td>Bassett Medical Center</td>
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<tr>
<td>Ellis Medicine</td>
<td>Crouse Health</td>
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<tr>
<td>Glens Falls Hospital</td>
<td>Mohawk Valley Health System</td>
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<td>Nathan Littauer Hospital</td>
<td>Oswego Hospital</td>
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<td>Samaritan Medical Center</td>
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<td>Upstate Medical University</td>
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<td>SPHP – Samaritan Hospital</td>
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<td>St. Mary’s Healthcare of Amsterdam</td>
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CORE HOSPITAL TOTAL: 17
Today:

- Select group of clinical leaders from Core Participating Hospitals
- Review rationale for IHA Opioid Alternative Project
- Present and review IHA Treatment Guidelines developed by all Core Participating Hospitals
- Present training curriculum to ensure consistent approach back in each ED
- Provide materials that can be used to train back in each ED
- Agree to timelines & expectations
- Provide communication strategies and plans
- Answer questions, allay concerns, and CREATE ENTHUSIASM!
Presented by:

William Paolo, MD
SUNY Upstate Medical University

Ross Sullivan, MD
SUNY Upstate Medical University
Learning Objectives

- Historical context and current state of opioid crisis and barriers to change
- Alternatives to opioids for pain treatment in the ED
- Review implementation of an opioid-reduction process and policy
Provider Training Goals

**GOAL 1**
Master the IHA Treatment Guidelines

**GOAL 2**
Develop a strategy for implementation in your ED

**GOAL 3**
Identify barriers

**GOAL 4**
Change your culture; join the IHA ALTO movement
GOAL 1: Master the IHA Treatment Guidelines

- 4 Pillars of Care
  - How can we address the opioid epidemic in the ED?
    - Limiting opioids from the ED
    - Alternatives to opioids for painful conditions (ALTO)
    - Harm reduction
    - Treatment of addicted patients and referral
Limiting Opioids from the ED

• Opioids are the most dangerous drug we prescribe. Every dose is playing with fire.

• How many of us...
  • Perform a patient risk assessment before offering an opioid?
  • Consistently check the PMP?
  • Counsel patients on medication risks?
  • Continue to prescribe opioids for back pain and headaches?
  • Know our prescribing practices
  • Removes preselected opioids from order sets
  • Stop wanting to prescribe them…fight the impulse, fight your own addiction
1. Non-opioid medications first
2. Opioids as rescue therapy and not used liberally
3. Multimodal and holistic pain management
4. Specific pathways exist
   1. Kidney stones
   2. Low back pain
   3. Fractures
   4. Headache
   5. Chronic abdominal pain
5. Requires more patient engagement:
   1. Discuss realistic pain management goals with patients
   2. Discuss addiction potential and side effects with using opioids
ALTO and Certa-Putting Science Back in Pain Control

http://www.propofology.com/infographs/certa-concept-of-analgesia
Alternative Treatments to Opioids for Painful Conditions

• How many of us prescribe alternatives for pain?
  • Ketamine
  • Toradol
  • Haldol
  • Gabapentin
  • Acetaminophen
Ketamine

- NMDA receptor antagonist
- When used at low doses, generally benign
- Used intranasally or intravenously
- PTSD is a contraindication
Ketamine

- Effect is dose-dependent
- Analgesia at doses less than or equal to 0.2 mg/kg slow IVP or 0.1 mg/kg/hr infusion
  - May be given in non-ICU areas
  - Slow administration rate (greater than 10 minutes) gives less adverse effects
- Ketamine 50 mg IN can also be given
  - No IV access
- Can be used adjunctively with opioids to reduce opioid requirements
Other options

• **Ketorolac**
  - 15 mg for everyone (IV or IM)
    - No difference in pain reduction between doses
  - Great for many indications including MSK pain and renal colic

• **Haloperidol**
  - Low dose (2.5-5 mg IV)
  - Great for nausea
    - Cannabinoid induced hyperemesis
Harm Reduction

- Addiction is not a moral failing; it’s a medical disease.
  - Do we treat addiction as a medical condition?
  - How many of us know how to shoot heroin?
  - Do we counsel our patients on IV drug use?
  - How many of us refer to SAPs?
  - How many of us prescribe naloxone?
  - Does your ED dispense naloxone?
Treatment of Addicted Patients and Referral

- We can do more to stop the epidemic
  - Does your ED have a SBIRT program?
  - How well do we facilitate MAT referrals?
  - How many of us have initiated buprenorphine in the ED?
  - Do we do a good job helping our drug dependent patients?
GOAL 2: Develop Strategies for Implementation in your ED

1. Support by your administration and Medical Director: this is one of your top goals for 2019.
2. Group buy in – Email / Communications.
3. ED physician meetings – Schedule your training, establish your culture.
4. Submit and use the data – take advantage of what IHA is offering and the Hawthorne Effect.
5. Keep at it – systematic change is an endurance sport.
GOAL 3: Obstacles to Implementation
If the policy doesn’t work...change the policy.

- Procedural sedation vs pain dose
  - Ketamine
- Scope of practice
  - Injections/blocks
- High-risk medication administration
  - Lidocaine
  - Ketamine
  - Nitrous oxide
- Procedural sedation vs pain dose
  - Ketamine
- Scope of practice
  - Injections/blocks
- High-risk medication administration
  - Lidocaine
  - Ketamine
  - Nitrous oxide
- EMS protocol change to lessen out of hospital opioid administration
- Training and experience of providers
- Staffing impact of need for additional patient education/counseling
- Impact on patient experience reviews
GOAL 4: Change your Culture; Join the IHA ALTO Movement

• By joining the IHA Opioid Alternative Project, you are joining a movement:
  – Hospital Association is with you
  – Hospital administration is with you
  – Nurses are with you
  – Pharmacy is with you
  – History and science are with you
Musculoskeletal

- Ibuprofen PO 600 mg or Ketorolac 15 mg IV/30 mg IM Lidoderm Patch
  - Spasm
    - Cyclobenzaprine 5 mg PO or Diazepam 5 mg PO
  - Ketamine
    - Gabapentin
    - Trigger Point Injections
    - Ketorolac
    - Dexamethasone
Headache

Prochlorperazine 10 mg PO / IV OR Metoclopramide 10 mg IV
Ketorolac 15 mg IV OR 30 mg IM
Sphenopalatine block, occipital block, or Trigger Point Injection
Acetaminophen 1000 mg PO + Ibuprofen 600 mg PO
1 L 0.9% NS + high-flow oxygen
Sumatriptan 6 mg SC

Lidocaine IV
Caffeine
Ketamine
Promethazine
Dexamethasone
Haloperidol
Magnesium
Valproic acid
Propofol

Diphenhydramine and 2nd dose of Metoclopramide at provider’s discretion
Abdominal Pain

Haloperidol 5mg IV
Acetaminophen 1000mg PO OR
Ketorolac 15 mg IV OR 30mg IM
Metoclopramide 10 mg IV
Prochlorperazine 10 mg IV
Diphenhydramine 25 mg IV
Dicyclomine 20 mg PO/IM

(Cannabinoid Hyperemesis)
Capsaicin Cream

Haloperidol
Ketamine
Lidocaine

Repeat First Approach drugs and diphenhydramine as secondary medication at provider's discretion
Renal Colic

Acetaminophen 1000 mg PO or IV
Ketorolac 15 mg IV OR 30 mg IM

1 L NS Bolus and Antiemetic as needed

Lidocaine IV AND/OR Ketamine
Dental Pain

Acetaminophen 1000 mg PO
Ketorolac 30 mg IM
Dental Block
Next Steps

Jessica Morelli, Vice President
Iroquois Healthcare Association

John McCabe, MD
Clinical Project Consultant
## Timelines

<table>
<thead>
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<th>April 1 – June 1, 2018</th>
<th>June 1, 2018 – December 2018</th>
<th>December 2018 – March 31, 2019</th>
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<tbody>
<tr>
<td>• Project Development</td>
<td>• Development: Protocols &amp;</td>
<td>• Trainings Begin: December</td>
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<td>• IHA Board Engagement</td>
<td>Guidelines</td>
<td>10th /11th</td>
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<td>• Discussions with</td>
<td>• IHA Member Participation</td>
<td>• Data Collection</td>
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<tr>
<td>Colorado</td>
<td>• Coordinate Data</td>
<td>• Reporting</td>
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<td>• Development: Education/</td>
<td>• Final Results</td>
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<td>Training</td>
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Data Collection & Reporting

Engaged RHIOs

Facility Data Reporting

Facility Self Reporting
Data Collection & Reporting

- De-identified Patient Demographics
- Emergency Department Data
- Pharmacy Administration Data
- Diagnoses for Visit
Communications Toolkit

• Intended to help your hospital communicate to various audiences about the IHA Opioid Alternative Project

• This toolkit provides several communication tools to assist your hospital in effectively messaging the purpose and goals of the program
Communications Toolkit

- Newsletter article
- Press release
- IHA Opioid Alternative Project
- PowerPoint presentations
- Staff emails
- Website content
- Media talking points
- Additional Resources
Questions?